MINISINK VALLEY CENTRAL SCHOOL DISTRICT
Office of the School Nurse
PO Box 217, Slate Hill, NY 10973

Daily Medication Log

Authorization for Administration of Medication

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child ____ grade ________ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the absence of the school nurse, will administer the medication.

Signature Parent/Guardian: ____ Date: ___________________

Address: ____

Home Phone: __________________ Work Phone: ____________________ Cell Number: ____________________

TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

I request that my patient, as listed below receive the following medication:

Name of Student: ____ Date of Birth: _____________

Diagnosis: ____

Name of Medication: ____

Prescribed dosage, frequency and route of administration: ____

____

Time to be taken during school hours: ____

Duration of treatment: ____

Possible side effects and adverse reactions (if any): ____

____

Other recommendations: ____

____

Name of licensed prescriber and title (please print): ____

Prescriber's Signature: ____ Date: _________________

Address: ____ Phone: _________________